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**Vision Rehabilitation Workforce Planning**

1. **Vision rehabilitation and the legal framework**

Loss of vision and blindness can have a profound physical, social and emotional impact on all aspects of daily life. Vision is central to everyday functioning. Vision rehabilitation seeks to restore an individual’s skills, confidence and wellbeing. The [2016 ADASS position statement](https://www.adass.org.uk/adass-position-statement-on-vision-rehabilitation-may-2016) on vision rehabilitation states that the core purpose of adult care, as supported by the Care Act, is to help people achieve the outcomes that matter to them. In addition to the duty on local authorities to assess and provide support for blind and partially sighted people is the duty to prevent, reduce and delay the need for future care support. Guidance to the prevention duty also recognises the clear benefits of vision rehabilitation support.

1. **Vision rehabilitation – the economic benefits**

Independent research by the Office for Public Management (OPM) and based on a case study of services provided by Sight for Surrey has shown that the financial benefits of good vision rehabilitation services significantly outweigh the actual costs of delivering this service. In the case study site, over £3.4 million of health and social care costs were avoided, reduced or deferred annually based on a service which cost an estimated £900,000 a year to deliver.

1. **Vision Rehabilitation – the profession**

Vision rehabilitation has a defined professional skill set, regulated by the professional body, the Rehabilitation Workers Professional Network (RWPN). In England employers agreed a defined set of knowledge, skills and behaviours that must be achieved as part of the governments Rehabilitation Worker trailblazer apprenticeship standard. Some aspects of skills training with blind people are risk-intensive. Only professionals who undertake the mandatory two year training can become registered professionals. Currently registration is voluntary, through the professional body, but an application is on-going to the Professional Standards Authority to join the government’s Accredited Voluntary Register scheme.

1. **Vision Rehabilitation – the employment situation in England**

RWPN’s workforce survey carried out in 2020 estimates that a quarter of the workforce have been employed for at least 20 years and that 12% of the workforce plan to retire in the next three years. RWPN estimates that, to meet current need, there is short fall of around 50 full-time equivalent qualified professionals.

1. **Calculating the workforce ratio**

RWPN believes there should be **1 FTE Vision Rehabilitation Worker to every 117,000 of the local authority population.**

The population data used in calculating incidence rates of low vision has been drawn from RNIB’s sightloss datatool, research carried out by the Social Policy Research Unit (SPRU) University of York (2014) and OPM (2017). The data relating to workforce patterns has been drawn from RWPN members across the four nations from a survey in 2020.

In tandem with the low numbers of Vision Rehabilitation Workers, RNIB estimate that between 2015 and 2020 the number of people who are blind or partially sighted in England has increased by 12 per cent, and by 2025, the number will have increased by 27 per cent.

**RWPN September 2020**

**Appendix**

**Principles used in choosing and interpreting data**

* Any individual “case” work will involve a process that includes a) specialist assessment and b) subsequent provision of rehabilitation and/or equipment
* When looking at impact on service provision it is more relevant to measure “incidence” of visual impairment in a locality (i.e. new vi referrals) rather than prevalence (i.e. total vi population)
* The only standard measure of “incidence” is the number of Certificates of Vision Impairment (CVI) that are counted by local authority area. However, CVI referrals are only a percentage of referrals that a service will receive. Referrals will come from other professionals, such as Eye Clinic Liaison Officers, Occupational Therapists and Social Workers. They will also come from blind or partially sighted people themselves. A significant number of referrals are actually re-referrals (referrals back into a service) where an individual’s sight has worsened or their overall needs have changed
* RWPN has used the statistics of incidence for England as a whole (rather than at a local authority level) because we believe it presents a more reliable picture. Data of CVI incidence at an individual local authority level appears unreliable due to uneven reporting

**Current evidence and comment**

* Incidence of CVI = **42 per 100,000** England average. Source RNIB sightloss datatool
* Percentage of additional referrals in addition to CVI **30%**. RNIB’s cost-avoidance research cites a figure of 15-20% uplift. However, our experience suggests this figure is too low. We believe this figure needs further research but does not reflect the wide network of referral routes into services or the increasing numbers of blind and partially sighted people.
* Case load – **20** at any one time. The only published research of case load studied three sites in England. The range was: 13-25; 12-36; 15-50 per worker (source York University Social Policy Research Unit (SPRU). Amongst full-time workers the most frequently stated (mode) case load from RWPN’s survey was 20.
* Yearly case load – **70 per ear for FTE**. Source: SPRU.
* 40% of total caseload require rehab (i.e. 60% of cases end after the initial specialist assessment). Source RNIB Cost-Avoidance research
* Length of engagement with client. The time spent with any one client will vary enormously according to need, as outlined in ADASS guidance. RNIB cost avoidance research gives a range of between 1-30 visits per client. RWPN has chosen a mode average (i.e. the most common duration) is 5 visits in addition to the initial assessment

**Assumptions about working patterns for a Full time worker**

* 47 weeks per year (52 minus annual leave allowance). In reality 47 weeks is an over-estimate of available time for case work because workers will attend staff training, meetings and undertake duty screening
* Rolling case load of 20 with one added per week and one closed per week. (Patterns will vary enormously based on length of case work and patterns in the working week, so this assumption keeps case load constant)

**Putting these assumptions into a practical calculated example**

* Applying this to a local authority population. Assume local authority with population of 250,000. This means 105 CVI will be received. If 30% of referrals are non-CVI this means the total referrals for assessment and rehab will be 150 per year
* Of these 150 assessment visits 40% of which will require rehab (60 cases). Each of those 60 cases will require 5 sessions of rehab each = 300 sessions of rehabilitation
* You can either view the case load of the whole service as a) **150 cases a year** or b) **450 visits/sessions per year** (150 assessments plus 300 sessions of additional rehab). Basing the calculation on the former figure is simpler
* So if a full time worker works 70 cases a year per year and if there are 150 cases a year, the number of workers required to meet 150 cases = 150 divided by 70 = 2.14 FTE workers
* Population of 250,000 = 2.14 full time workers. This equates to one full time worker for **117,000**. **1:117,000**

Note: It is important to note that this calculation is a Full Time Equivalent figure. Around 25% of respondents to RWPN’s survey said they worked fewer than 29 hours a week.